STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155600	A. BUILDING 01 B. WING _____	R 03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY HEALTH & REHABILITATION CENTER	502 W JACKSON ST MULBERRY, IN 46058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/08/10 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/02/11 Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210 Surveyor: Bridget Brown, Life Safety Code Specialist At this PSR survey, Mulberry Health and Rehabilitation Center, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupanciesfor building 0101, Chapter 18, New Health Care Occupancies for the 400 hall west wing, and 410 IAC 16.2 for all sections. This facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101 was built prior to March 1, 2003, therefore it was surveyed in accordance with LSC Chapter 19. It was determined to be of Type V (111) construction and was fully sprinklered. Building 0202 determined to be of Type V (111) construction was fully sprinklered, built in 2004 and consisted of 14 additional rooms on the 400 hall, west wing, surveyed in accordance with LSC Chapter 18.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 159 and had a census of 137 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/04/11.	{K 000}		